STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005093	A. BUILDING: _____ B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITHAM HEALTH SERVICES	2605 N LEBANON ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a State hospital complaint investigation. Complaint: #IN00127558 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005093 Survey Date: 05/29/2013 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Witham Health Services is in compliance with 410 IAC 15-1.5-6, Nursing service, 410 IAC 15-1.5-7, Pharmaceutical services, and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules. QA: claughlin 06/18/13	S 000		